



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## ***MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION***

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

MEMORIAL HERMANN HOSPITAL SYSTEM  
3200 SW FREEWAY SUITE 2200  
HOUSTON TX 77027

DWC Claim #:  
Injured Employee:  
Date of Injury:  
Employer Name:  
Insurance Carrier #:

#### **Respondent Name**

TEXAS MUTUAL INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 54

#### **MFDR Tracking Number**

M4-08-7036-01

#### **MFDR Date Received**

AUGUST 5, 2008

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "The hospital submitted a final bill on August 22, 2007 with total charges of \$29,872.50. My client received partial payment totaling \$6,405.35 on October 17, 2007. The carrier did not perform an audit of the hospital's usual and customary charges... The amount paid by the carrier falls below the hospital's expected reimbursement rate. My client expected a fair and reasonable reimbursement since there is no particular fee guideline establishing a maximum amount recoverable under the Acute Care Inpatient Hospital Fee Guideline (ACIHFG) found in Commission Rule 134.401. Because this admit was a trauma/burn falling within diagnostic codes ICD9 – 800.0 – 859.5, the entire admission should be reimbursed at a fair and reasonable rate under Rule 134.401(c)(5). The carrier instead paid the claim under an unknown methodology, which resulted in an approximate 22% reimbursement rate for treatment of this major trauma patient. A reduction in excess of 78% of the hospital's usual and customary charges is on its face inherently unreasonable, especially for treatment of a severe trauma victim. It is the hospital's position that a unilateral, arbitrary reduction of its usual and customary charges by over 78% is inherently unfair and unacceptable from a commercial insurance company. Even negotiated managed care rates provide reimbursement levels much higher than 22%. The carrier has not and cannot demonstrate that a reduction of total charges by over 78% constitutes a fair and reasonable rate of reimbursement, especially for treatment of this trauma patient. The Division recognized the unpredictable nature of treating trauma and burn patients when it carved out these IDC9 codes from the standard per diem reimbursement methodology, Rule 134.401(c)(5). It is a generally accepted principle that treatment of trauma and burn patients is more costly than a scheduled, controlled surgery or diagnostic procedure."

**Amount in Dispute:** \$23,467.15

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "The requestor seems to be saying that since 22% payment by Texas Mutual is in no way fair and reasonable that somehow this justifies the requestor's assertion that 100% payment of its usual and customary charge of \$29,872.50 is fair and reasonable. The requestor goes on to make the statement that since Texas Mutual did not audit its billing that makes its billing fair and reasonable. Texas Mutual is unaware this one of the criteria for fair and reasonable... The requestor argues further that Texas Mutual did not supply '...a copy of any alleged data research, market analysis or other documentation to support their unilateral reduction of the hospital's usual and customary rates.' Presumably, such data would support Texas Mutual's position that its payment is fair and reasonable... In turn, Texas Mutual could also argue that the requestor did not supply a copy of any alleged data research, market analysis or other documentation to support the unilateral billing of its usual and customary rates meets the criteria of the Labor Code at 413.011 for a fair and reasonable charge. The requestor goes on to argue that the '...carrier has not and cannot demonstrate that a

reduction of total charges by over 78% constitutes a fair and reasonable rate of reimbursement...'... Box 69 of the requestor's bill shows the admitting diagnosis is 729.5. This diagnosis code does not fall in the range of trauma diagnosis codes given by the applicable hospital fee guideline, i.e. Rule 134.401. True, two other diagnosis codes are listed- 824.2 and 825.32, and these do fall within that range of codes but the diagnosis which was used to admit the claimant into the requestor's facility and assigned by the requestor was 729.5. Diagnosis code 729.5 plus a total billed amount less than \$40,000.00 makes the payment methodology per diem according to Rule 134.401. Since the claimant had surgery to the ankle the per diem is \$1118.00 per day. The admission was five days or \$5,590.00. The implants are to be paid at cost plus 10%, which total \$213.95. There are no other carve outs listed on the bill. Therefore, the grand total is \$5,803.95. When this figure is divided by the billed amount of \$29,872.50 then multiplied by 1.00, the resulting percentage reduction of the requestor's bill is 80.5%. And this 80.5% reduction results in an amount that is fair and reasonable if one assumes the MAR is fair and reasonable. Texas Mutual paid \$6,405.35, an over payment for which it is not requesting a refund."

**Response Submitted by:** Texas Mutual Insurance Co., 6210 E. Hwy. 290, Austin, TX 78723

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2007 through August 11, 2007	Inpatient Services	\$23,467.15	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-W10-No maximum allowable defined by fee guideline. Reimbursement made based on insurance carrier fair and reasonable reimbursement methodology.
  - CAC-97-Payment is included in the allowance for another service/procedure.
  - 217-The value of this procedure is included in the value of another procedure performed on this date.
  - 426-Reimbursed to fair and reasonable.
  - 719 – Reimbursed at carrier's fair & reasonable; cost data unavailable for facility. Additional payment may be considered if data is submitted.
  - CAC-18 – Duplicate claim/service.
  - 224 – Duplicate charge.
  - W4 – No additional reimbursement allowed after review of appeal/reconsideration.
  - 791 – The insurance company is reducing or denying payment after reconsideration..

#### **Findings**

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 66 on the hospital bill finds that the principle diagnosis code is listed as 842.2. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures

that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
  - The requestor seeks full reimbursement of billed charges based upon “It is the hospital's position that a unilateral, arbitrary reduction of its usual and customary charges by over 78% is inherently unfair and unacceptable from a commercial insurance company.”
  - The requestor did not provide documentation to demonstrate how it determined that full reimbursement of billed charges was fair and reasonable.
  - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
  - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
  - The Division has previously found that “hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that “Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges...” 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
  - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
  - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
  - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### Authorized Signature

_____	_____	November 29, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

## YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**